Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: THE SAN ANTONIO ORTHOPAEDIC SURGERY CTR LOMA STOUT 400 CONCORD PLAZA SUITE 200 SAN ANTONIO TX 78216	MFDR Tracking #: M4-04-2061-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: TASB RISK MGMT FUND Box #: 47	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Rationale for Increased Reimbursement: "Not paid fair and reasonable."

Requestor's Letter Requesting Reconsideration of Payment states "Portion of the claim has been reduced or not considered in the amount of $19,268.75 contending the amount billed being above the usual, reasonable and customary charge. According to the Statutes established by the State and the rules of Health Care Financing Administration (HCFA) stipulate that in the absence of an established fee guideline for an acute specialized status of care, the fees are to be computed according to an accredited itemized charge index recognized by the official medical authority of the State (Department of Health), and is updated in uniformity with the current Consumer Price Index for the specific computations in each tax zone to determine an appropriate reasonable and customary. Accordingly, we are not in agreement with your stated position and are requesting that the entire amount reduced for such contention be paid. If no such additional payment is made and the previous decision is still sustained, please provide backup detailed copy of the charge index that was used to compute this reduction in accordance to the Statutes, as our charges were provided in detail, to determine the validity of this reduction or your reduction shall be considered formally unsupported and unjustified."

Principal Documentation:

1. DWC 60 Package
2. Medical Bill(s)
3. EOB(s)
4. Medical Records
5. Total Amount Sought - $19,268.75

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "M"

Principal Documentation:

1. Response Package

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
6/26/2003	ASC facility charges for 29888	Not Applicable	$6,754.00	$0.00
6/26/2003	ASC facility charges for 29881	Not Applicable	$6,148.00	$0.00
6/26/2003	ASC facility charges for 29877	Not Applicable	$6,148.00	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

Texas Labor Code § 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective May 2, 2006 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on October 13, 2003. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on October 17, 2003 to send additional documentation relevant to the fee dispute as set forth in the rule.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
   - M-No MAR.
   - M-Pmt amnt based on Medicare Grp rates at 130%, mult. Proc rule applies. [sic]
   - O-Denial after reconsideration.
2. Division rule at 28 TAC §134.401(a)(4), effective August 1, 1997, states "Ambulatory/outpatient surgical care is not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific types of reimbursements."
3. This dispute relates to ambulatory surgical care services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 2, 2006, 31 TexReg 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. Division rule at 28 TAC §133.307(g)(3)(C)(iii), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the Texas Labor Code and commission [now the Division] rules, and fee guidelines, impact the disputed fee issues." Review of the submitted documentation finds that the requestor did not state how the Texas Labor Code and Division rules impact the disputed fee issues. The Division concludes that the requestor has not provided documentation sufficient to meet the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(iii).
6. Division rule at 28 TAC §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the requestor did not state how the submitted documentation supports the requestor's position for each disputed fee issue. The Division concludes that the requestor has not provided documentation sufficient to meet the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(iv).
7. Division rule at 28 TAC §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's rationale for increased reimbursement from the *Table of Disputed Services* states that "Not paid fair and reasonable."
   - The requestor's position in the request for reconsideration letter is "According to the Statutes established by the State and the rules of Health Care Financing Administration (HCFA) stipulate that in the absence of an established fee guideline for an acute specialized status of care, the fees are to be computed according to an accredited itemized charge index recognized by the official medical authority of the State (Department of Health), and is updated in uniformity with the current Consumer Price Index for the specific computations in each tax zone to determine an appropriate reasonable and customary."
   - The requestor did not provide documentation, such as itemized charge index or Consumer Price Index, to support the amount being sought.
   - The requestor does not further discuss or explain how the amount in dispute was calculated or arrived at.

- The requestor does not explain how it determined that payment of the amount in dispute would result in a fair and reasonable reimbursement for the disputed services.
- The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
- The requestor does not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the requirements of Texas Labor Code §413.011(d) or Division rule at 28 TAC §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

8. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(g)(3)(C) and §133.307(g)(3)(D). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services involved in this dispute.

		7/26/10
Authorized Signature	Medical Fee Dispute Resolution Officer	Date
		7/26/10
Authorized Signature	Medical Fee Dispute Resolution Manager	Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.